Department of Health
Child and Adolescent Mental Health Division

Performance Report

Performance Period October 2005-December 2005

Introduction

This report presents findings about the performance of operations and services of the Child and Adolescent Mental Health Division (CAMHD) during the second quarter of fiscal year 2006 (October 2005-December 2005). The information used for this report is based on the most current data available, and where possible are aggregated at both statewide and district or complex levels. Tracking and analyses of data provides information that allows stakeholders to determine how well CAMHD is delivering care and impacting child outcomes.

Data in this report are presented for four major areas:

- Population: Population information describes the demographic characteristics of the children and youth served by CAMHD.
- Service: Service information is compiled regarding the type and amount of direct care services provided.
- Cost: Cost information is gathered about the financial aspects of services.
- Performance Measures: Performance Measures, including Outcome data, are used to understand and track the quality of services over time and the performance of operations of the statewide infrastructure designed to provide needed supports for children, youth, and families. Outcomes are further examined to determine the extent to which services that are provided lead to improvements in the functioning and satisfaction of children, youth and families.

How Measures Are Selected and Used

CAMHD has successfully used performance measures over a number of years. The key utility of measuring quality and performance is the ability it gives to align organizational goals with achieving results in core areas of service provision and supporting infrastructure. CAMHD worked through a process of moving from "fear of accountability" and measurement, to counting on the data to allow for open discussion about needed improvements. Measures are used to coordinate the work of the organization in order to achieve timely, cost-effective services that ultimately improve the lives of children, youth and families served.

The CAMHD Performance Management system allows CAMHD, at all levels, to look at its performance and use this information to make decisions about adjustments to its program. Performance data in CAMHD are tracked systematically across all aspects of service delivery and care. Services are monitored through tracking of trends and patterns found in utilization, program performance and satisfaction data, and examinations of practice and quality of services. This information helps determine how well the system

is doing for youth, and how well youth are progressing. It is sensitive enough to ascertain if the system is performing better or worse for certain populations, and comprehensive enough to detect what aspects of care, and in what settings, problems may be occurring.

Further studies and special reports on the CAMHD population and services, including past editions of this report can be accessed at the CAMHD website at http://www.hawaii.gov/health/mental-health/camhd/resources/index.html.

Quality Improvement Highlights

Highlights of key activities conducted during the quarter include:

⇨ A Request for Proposals was released in November for Comprehensive Behavioral Health Services for Children, Youth and Families. Services procured through the RFP will begin in July 2006. The Interagency Performance Standards and Practice Guidelines, which are a requirement for implementing services under the RFP, were updated in collaboration with the Department of Education and other stakeholder groups to reflect the state-of-the-art in best practices, evidence-based services, and most promising interventions for youth and families. The goals of the RFP are to:

- Provide eligible youth with timely access of community and evidence based services that are provided by qualified staff within a system of care that embodies Hawaii CASSP,
- Promote the use of current knowledge of evidence-based services in the implementation of individualized plans and services,
- Demonstrate an accountable and efficient children's mental health system,
- Implement an effective and efficient publicly managed behavioral health plan for Medicaid eligible youth with the most serious emotional challenges, and
- Demonstrate an effective, integrated cross-agency system of services for educationally disabled students who need mental health services in order to benefit from their education.

⇨ The CAMHD Statewide Management Team convened in January to discuss progress in implementing system improvements managed by respective discipline groups (e.g.: Clinical Directors, Family Guidance Center Branch Chiefs, Psychologists, Quality Assurance Specialists, etc.). A crucial activity over the next several quarters will be the evaluation of CAMHD's Strategic Plan, and development of the new plan that will cover the next four years (2007-2010).

⇨ The Annual Evaluation Report of the CAMHD service system was completed in the quarter. The evaluation provides detailed analyses and critical review of the information gathered during the annual evaluation process. Key findings are:

Population size and access to services. Fiscal year 2005 was the first year since 2001 that the total number of youth registered with CAMHD did not decline (+1% growth). In fact, the number of youth with services procured increased (+8%). Growth was driven by increased enrollment in the QUEST behavioral health plan (+19%). Youth receiving education-related mental health services continued to decline (-2%), but at a slower rate than in prior years. Recommendations from prior annual evaluation reports targeted the goal of

expanding the overall number of youth served by CAMHD to reduce the prevalence of unmet needs in the community.

Conduct Disorder and Its Precursors. The prevalence and challenges related to treatment have led disruptive behavior disorders to repeatedly emerge as a special need. Disruptive behavior disorders surpassed attentional disorders as the most common problem among youth registered with CAMHD. Almost one out of every two youth (48%) had a primary or additional diagnosis in the disruptive behavior category. Multisystemic therapy is an evidence-based service to help youth with misconduct. The number of youth receiving multisystemic therapy had decreased during FY 2004, but utilization increased during FY 2005 to around the FY 2003 level. A request for proposals was released to establish new Multidimensional Treatment Foster Care services, another evidence-based service for youth with disruptive behaviors, with services scheduled to begin in FY 2006.

Community Residential Services. Halting the trend toward increasing utilization of community residential services was another common target of previous years' report recommendations. For the first time since 2001, the number of youth receiving community residential services did not increase over the previous year. In fact, as a relative proportion of all youth receiving services, the utilization of community residential services slightly decreased (-2%), as did the number of average hours of service per youth (-2%). However, unit cost increases were associated with greater total expenditures and cost per youth for community residential services. Thus, success was achieved in containing growth of community residential services, but it remains a relatively high use, high cost service.

Evidence-Based Practices. CAMHD invests considerable resources in developing therapeutic practices to more closely resemble the types of practices supported by scientific studies. Over the past year, little change was observed in the pattern of therapeutic practices reported by service providers. Compared to evidence-based service protocols, actual care included both evidence-based and non-evidence-based practices. However, CAMHD providers reported using a greater variety of practices and using practices that had received less frequent support in research studies. This finding was consistent across diagnostic problem areas. Thus, considerable opportunity remains to evolve therapeutic practices to be more evidence-based.

Early Detection and Intervention. The average age of youth registered with CAMHD had declined in recent years, but this trend did not continue during fiscal year 2005. Further, the average child status scores for youth newly registered with CAMHD have remained generally stable over the past five years across measurement instruments. Thus, the available evidence indicates that little progress has been made in systematizing earlier detection and intervention. However, CAMHD has reallocated some of its federal block grant funds to further support prevention and early intervention efforts, which were not directly assessed for this evaluation. Identifying youth at a younger age or with less severe functioning was the objective of a host of recommendations from prior evaluations.

Child Status at Discharge. The average child status scores for youth discharged from the CAMHD system indicate that youth are displaying more problematic functioning and greater service needs than youth discharged in prior years. The majority of CAMHD youth are showing improvement with treatment and the treatment gains are typically occurring more rapidly than several years ago, but youth may be discharged with somewhat greater impairment. This change is occurring in the context of a larger overall population and a reduction in service intensity. The size of the family guidance center workforce has remained generally stable, caseloads have increased near the high end of the targeted range, job vacancy rates have increased somewhat, and some vacant positions were eliminated. These factors may coincide to create an environment that encourages earlier discharge of youth who have improved with services, but who may not have improved quite as much as in recent past. Alternatively, the more rapid improvement may lead families and professionals to believe that termination of services at greater levels of impairment is appropriate because positive therapeutic momentum may continue with less intensive mental health services or informal supports. Further exploration of this phenomenon is advised.

Hospital Residential Services. Prior to fiscal year 2003, reducing utilization of hospital residential services and out-of-state services were key quality improvement goals. On a positive note, the number of youth receiving out-of-state services has continued to remain low. Unfortunately, the same is not true with respect to utilization of hospital residential services. The number of youth, total hours of service, average monthly census, and total cost of hospital residential services have increased. Although the number of youth receiving this service remains 12% below the FY 2002 level, it has increased by 39% since FY 2003. Therefore, reconsideration of more aggressive strategies for sustaining prior progress is recommended.

Overall Summary of Findings

The overall results from the data and analysis presented below suggest that in general, CAMHD's functioning is comparable to that of previous quarters except in the area of vacancies. Human resources, particularly hiring and retaining qualified mental health care coordinators, remains a challenge that requires ongoing attention to stability in this core infrastructure component. The total number of youth served continued to decline slightly, but the total size of the CAMHD population is larger than it was a year ago. Service utilization trends for both Hospital and Community Residential service continued to decrease. Utilization of Therapeutic Foster Homes also decreased over last quarter, but increased over the same period last year. The proportion of youth enrolled in the QUEST behavioral health plan reached another all-time high for CAMHD consistent with CAMHD's efforts to maximize the use of federal funds.

Data Sources

Data regarding the population served, access and use of services, cost, treatment processes and outcomes is generated at the Family Guidance Centers or through billing information, and collected through the Child and Adolescent Mental Health Management Information System (CAMHMIS). CAMHMIS produces data reports that are used by staff and management for tracking, decision-making, supervision and evaluation.

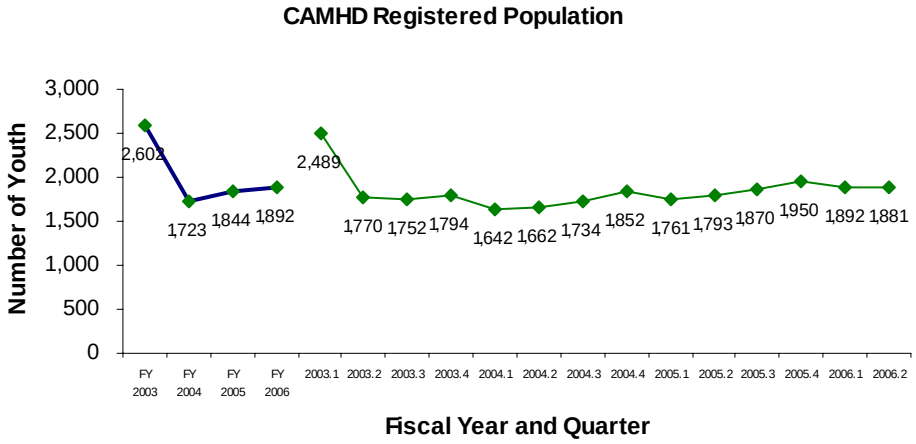
CAMHMIS' multiple features include the ability to generate "live" client data, FGC-specific reports and other special reports that aid in performance analysis and decision-making. Additional data elements used to track Performance Measures are produced by various databases maintained at the State Level.

Population Characteristics

Population data presented here are for youth registered through the CAMHD Family Guidance Centers during the second quarter of fiscal year 2006 (October 2005-December 2005). In the quarter, CAMHD Family Guidance Centers provided care coordination for 1,881 youth across the State, a decrease of 11 from the previous reporting quarter (July 2005-September 2005 based on data as of September 30, 2005), or a 1% decrease in the total population over last quarter. Decreases in the registered population were experienced in more than half of the Family Guidance Centers.

On a year-to-year basis, CAMHD is continuing to show overall growth in its registered population. In comparison to the same period of last year (October 2004-December 2004), CAMHD has experienced a 5% overall increase in its registered population. Despite this growth, CAMHD continues to serve fewer youth than expected based on estimates of the prevalence of severe emotional and behavioral problems in the general population. Expanding outreach to unserved populations and increasing overall population size has been identified as a need.

The chart below reflects changes in the CAMHD population over time.



Note: The drop in population at the start of fiscal year 2003 (July 2002) corresponds to the shift in management of services to youth with pervasive developmental disorders from CAMHD to the Department of Education.

The number of youth registered at each of the Family Guidance Centers during the second quarter (is displayed in Table 1). The number for Kauai (KFGC) are for the Mokihana Project in total, which serves youth with both low and high intensity mental health needs. The largest population, consistent with historical data, continued to be served on the Big Island through the Hawaii Family Guidance Center (HFGC). HFGC served 22.8% of the total CAMHD population during the quarter. The Leeward Family Guidance Center (LFGC) serves the largest population on Oahu, and 13.3% of the CAMHD registered youth. The Family Court Liaison Branch (FCLB), which provides services primarily for incarcerated and detained youth, continued to serve the smallest registered population (2.3%).

Table 1. Population of Youth Registered by Family Guidance Center, FY 2006, Quarter 2 (October 2005-December 2005)

COFGC	LOFGC	MFGC	WFGC	HOFGC	HFGC	KFGC	FCLB
156	251	162	141	170	429	528	43

The total number of registered youth are described by four subgroups: (*i*) youth who received both intensive case management services and direct services authorized through the CAMHD provider network, (*ii*) youth who were in the process of having services arranged (new admissions), (*iii*) youth who received less intensive services through Mokihana on Kauai, and (*iv*) youth who were discharged at some time during the quarter. There is also a percentage of youth who receive intensive case management services only. Of the total number of registered youth, 979 had services that were authorized within the quarter.

Of the registered population (1,881), 147 youth (7.8%) were newly registered (had not previously received services) in the second quarter of fiscal year 2006. This represents an increase of 52 new admissions from the previous quarter (July 2005-September 2005). Eighty-eight (88) youth (4.7%) who had previously received services from CAMHD were reregistered, a decrease from last quarter's readmissions of 110 youth. CAMHD discharged a total of 199 youth during the quarter, or 10.6% of the registered population. This is a decrease of 14 youth from last quarter's discharge of 213 youth, which was 11.3% of the registered population. Because youth may receive multiple admissions or discharges during the quarter for administrative reasons, these numbers estimate, but do not exactly reflect changes in the overall registered population size. Youth are generally discharged for several reasons, which can include attaining desirable treatment outcomes, graduation from school or "aging-out" of services, treatment refusal, or moving out of state.

This pattern of admissions and discharges suggests that the reduction in the total registered population is resulting from a decrease in the number of new admissions, not an increase in the number of discharges. In other words, the services for youth registered with the system apparently proceeded as is typical, but "pathways" into the system provided fewer youth.

The average age and age range has remained relatively stable among the CAMHD population over the past few years. The average age of registered youth in the reporting quarter was 14.3 years with a range from 3 to 20 years. However, there has been a multiyear tendency toward a decreasing percentage of males and increasing percentage of females in the CAMHD population. However, approximately two-thirds (65%) of youth served during the second quarter were male (see Table 2).

Table 2. Gender of CAMHD Youth

Gender	N	% of Available
Females	651	35%
Males	1,230	65%

CAMHD is continuing its effort to convert its collection of race and national origin data to be consistent with national standards. The national origin of youth is displayed in Table 3. The races of youth registered in the reporting quarter are displayed in Table 4. The valid completion rates for the new procedures remains low with 60.5% of youth missing national origin information and 42.3% of youth missing race information. To improve the quality of these data fields, additional online reporting capacity was added to

the Child and Adolescent Management Information System. Missing data rates for these fields were reviewed during quality committee meetings, and additional training for the Family Guidance Centers is occurring.

The high missing data rates make the generality of the available data dubious. However, the observed results are relatively consistent with prior quarters. Multiracial youth represented the largest racial group (61.6%), followed by White youth (17.1%), and then Native Hawaiian or Pacific Islanders (10.6%). National Origin data were not available (no data entered) for 60.5% of youth registered. Race data were somewhat more available this quarter than last quarter when 40.8% had race data recorded. This reflects the continued implementation of the new race and ethnicity recording system developed as part of the data infrastructure grant to meet federal reporting requirements.

Table 3. National Origin of Youth (Unduplicated)

National Origin	N	% of Available
Not Hispanic	528	71.1%
Hispanic or Latino/a	215	28.9%
Not Available (% Total)	1,138	60.5%

Table 4. Race of Youth (Unduplicated)

Race	N	% of Available
American Indian or Alaska Native	1	0.1%
Asian	90	8.3%
Black or African-American	16	1.5%
Native Hawaiian or Pacific Islander	115	10.6%
White	186	17.1%
Other Race	9	0.8%
Multiracial	668	61.6%
Based on Observation	140	12.9%
Not Available (% Total)	796	42.3%

Subpopulations of youth who receive services through CAMHD are also involved with other public child-serving agencies. These agencies include the Department of Human Services (DHS), Family Court, Hawaii Youth Correctional Facility (HYCF) or Detention Home, and the Med-QUEST Division of DHS (see Table 5). In the quarter, 8.9% were involved with DHS, which continues a multiyear pattern of a progressively smaller proportion of youth involved with DHS (e.g., 10.9% during the same period of FY 2005). At some point during the quarter, 23.8% had a Family Court hearing during the quarter, and 6.3% were incarcerated at HYCF or detained at the Detention Home. Both of these proportions decreased slightly from the previous quarter (25.2% and 6.8%, respectively) and remain below the same period from last year (25.5% and 7.3%, respectively).

Table 5. Agency Involvement

Agency Involvement	N	%
DHS	168	8.9%
Court	447	23.8%
Incarcerated/Detained	118	6.3%
SEBD	724	38.5%
Quest	729	38.8%

Services to youth who are QUEST-eligible and have a Serious Emotional and Behavioral Disturbance (SEBD) occurs by virtue of a Memorandum of Agreement (MOA) with the Med-QUEST Division. Youth who were eligible for services through the SEBD process numbered 724 and were 38.5% of the registered population. This was an increase of 10 youth, or a 1% increase in the SEBD category over the previous quarter (July 2005-September 2005).

QUEST-eligible youth who received services in the quarter were 38.8% of the population. This is the highest proportion of QUEST enrolled youth witnessed on this indicator since initiation of this report. Thus, the pattern of expanding services to QUEST youth continues. QUEST-eligible youth may also be eligible for services through CAMHD because of their educational or juvenile justice status.

Table 6. Diagnostic Distribution of Registered Youth

Any Diagnosis of	N	%
Disruptive Behavior	773	47.0%
Attentional	681	41.4%
Mood	575	35.0%
Miscellaneous	432	26.3%
Anxiety	331	20.1%
Substance-Related	266	16.2%
Adjustment	170	10.3%
Mental Retardation	35	2.1%
Pervasive Developmental	27	1.6%
Multiple Diagnoses	1,188	72.2%
Ave. Number of Diagnoses	1.9	

Note: Percentages may sum to more than 100% because youth may receive diagnoses in multiple categories.

Youth registered with CAMHD receive annual diagnostic evaluations using the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994). Children and youth may receive multiple diagnoses on the first two axes of the DSM system. To summarize this information, diagnoses are classified into primary categories and the number of youth receiving any diagnosis in each category is reported (see Table 6). The reported percentages may exceed 100% because youth may receive diagnoses in multiple categories.

The top three diagnoses of youth with registered services in the quarter were Disruptive Behavior disorders (47.0%), Attentional disorders (41.4%), and Mood disorders (35.0%). This quarter saw a decrease in the number of youth identified with Disruptive Behavior disorders, although there continues to be more youth with Disruptive disorders than those with Attentional disorders. Miscellaneous diagnoses accounted for 26.3% of youth in the CAMHD population. This category includes individual diagnoses that occur less frequently in the population including cognitive, psychotic, somatic, dissociative, personality, sexual, tic, impulse control, learning and eating disorders.

The majority of youth in the CAMHD registered population have co-occurring, or more than one diagnosis. In the reporting quarter, 72.2% of registered youth had more than one diagnosis, with an average of 1.9 diagnoses per youth. This is a slight decrease from the previous quarter (July 2005-September 2005) when 72.6% had co-occurring disorders. For those with services authorized, the percentage of youth with multiple diagnoses was even higher (77.4%) with an average of 2.2 diagnoses per youth, which means that over three quarters of youth that received services within the CAMHD array in the quarter had co-occurring diagnoses. This continues a long-term pattern of increasing diagnostic comorbidity among youth receiving CAMHD services. The co-occurring diagnoses category includes any DSM-identified disorder whether behavioral, developmental, emotional or substance-related.

In the quarter, youth with substance-related diagnoses represented 16.2% of the registered population, an increase of .1% from the previous quarter. This statistic may

not represent all youth with a substance-related impairment, or the number of youth with substance use identified as a target of intervention. Because diagnostic criteria for substance-related disorders require youth to exhibit a variety of symptoms and impairment, not all youth who use substances or who might benefit from interventions targeting substance use would be diagnosed with a substance-related disorder. Therefore, this statistic, which is drawn from the diagnostic category, is expected to underestimate the total number of youth experiencing a substance-related impairment.

Services

Service utilization information is used throughout CAMHD to assure efficient use and timely access to services. At the case level, service data are constantly reviewed to provide services based on child and family needs, and provision within the least restrictive environment. Tracking of utilization of the services at the aggregate level allows for accurate accounting, and data-driven planning and decision-making.

CAMHD tracks the utilization of services through CAMHMIS for services that are electronically procured. For services that are not electronically procured, information from the Clinical Services database is used to augment the CAMHMIS database to yield the final numbers reported here. CAMHD produces a separate detailed quarterly service utilization report with information regarding statewide utilization of services for all levels of care. As discussed previously, because utilization data are dependent on an accounting of claims adjudicated, it is not possible to present actual utilization for the current reporting quarter (October 2005-December 2005). Therefore, service authorization data are presented here, which closely approximates the actual utilization for the quarter for most levels of care.

Home and community based services continue to account for the majority of services provided to youth. Specifically, 49.7% of youth with service authorization received Intensive In-Home (IIH) services and 14.9% received Multisystemic Therapy (MST). These home and community services were provided at a level that was comparable to same period of the prior year, with a small tendency toward greater relative utilization of IIH and lower relative utilization of MST.

Table 7. Service Authorization Summary (October 1, 2005-December 31, 2005).

Any Authorization of Services	Monthly Average	Total N	% of Registered	% of Served
Out-of-State	6	6	0.3%	0.6%
Hospital Residential	19	29	1.5%	3.0%
Community High Risk	7	9	0.5%	0.9%
Community Residential	107	146	7.8%	14.9%
Therapeutic Group Home	70	90	4.8%	9.2%
Therapeutic Family Home	130	153	8.1%	15.6%
Respite Home	0	0	0.0%	0.0%
Intensive Day Stabilization	0	0	0.0%	0.0%
Partial Hospitalization	0	0	0.0%	0.0%
Day Treatment	0	0	0.0%	0.0%
Multisystemic Therapy	106	146	7.8%	14.9%
Intensive In-Home	413	487	25.9%	49.7%
Flex	95	161	8.6%	16.4%
Respite	20	23	1.2%	2.3%
Less Intensive	50	126	6.7%	12.9%
Crisis Stabilization	4	8	0.4%	0.8%

Note: Youth may receive more than one service per month and not all youth will have a service procured each month, so the percentages may add to more or less than 100%. The monthly average to total census ratio is an indication of youth turnover with a high percentage indicating high stability.

The largest group of youth in an out-of-home setting received services in a Community-Based Residential program (14.9%). The percentage of youth receiving these services

decreased slightly from the previous quarter (15.4%) and from the same period of last year (16.5%). Similarly, the use of Hospital-based Residential (HBR) services (3.0% during period) decreased slightly from the previous quarter (3.2%) and from the same period of last year (3.6%). This recent decline reverses a trend toward increasing utilization of HBR in recent years.

Although there is a decreasing utilization of the most restrictive out-of-home services, the utilization of Therapeutic Family Homes (15.6%) decreased slightly this quarter over the previous quarter (15.9%), but increased over the same period of last year (14.3%). Utilization of Therapeutic Group Homes (9.2%) has fluctuated a bit from quarter to quarter (down from 9.6% in the previous quarter), but is slightly above the same period of last year (9.0%).

In the reporting period, Ancillary Services paid for through Flex funding were provided for 16.4% of registered youth, which was a slight decrease from last quarter's utilization of these services for 17.0% of the registered population. Ancillary Services are designed to maintain youth in their homes (prevent out-of-home placements) through supports that are not found in the regular array of services, or to pay for specialized services. The largest use of Flex funding was to pay for travel cost for youth in out of home settings.

Respite Home services had no youth accessing this service, as opposed to 0.6% of the served population receiving an authorization for this service last quarter. On an annualized basis, utilization has increased somewhat, but overall utilization of this service remains low. Respite Homes were designed to support caregivers' capacities and prevent potential out-of-home placements. The consistently low utilization of this service indicates either little need for this service or that potential barriers existing to accessing this service. One identified obstacle involves the funding and payment structure for these homes. Therefore, payment is being restructured to remove this obstacle for this level of care within the next generation of the service array. There was also no utilization of Intensive Day Stabilization Services. Respite services are a different level of care than Respite Homes in that they do not need to be provided by a Therapeutic Foster Home provider and are more flexible in nature. Utilization of Respite services decreased with 2.3% of youth accessing these services in the quarter.

Cost

CAMHD uses several sources of information about expenditures and the cost of services to understand cost across all services delivered. Services billed electronically and purchased through the provider network are recorded directly by CAMHMIS when the records are approved for payment (a.k.a. accepted records). Because cost data are available the quarter following the adjudication of all claims, the cost data discussed below represents expenditures for services provided during the first quarter of fiscal year 2006 (July 2005-September 2005). Unit cost information may not be available in CAMHMIS for certain types of services or payment arrangements (e.g., cost reimbursement contracts, emergency services). For these services, wherever possible, service authorizations are used to allocate the cost of services (e.g., Flex, Mokihana, Multisystemic Therapy, Out-of-State, Respite) to specific youth and Family Guidance Centers.

Detailed allocation of cost information for the reporting quarter by each level of care is presented in Table 8. Out-of-Home residential treatment services in Hawaii accounted for 83.1% of service expenditures, which is 0.5% below the previous quarter's percentage of cost. Youth in Out-of-State treatment settings accounted for 1.1% of total expenditures, which is 0.3% above the previous reporting quarter's (April 2005-June 2005) proportion of cost.

Table 8. Cost of Services (July 2005-September 2005)

Any Receipt of Services	Total Cost ($)	Cost per Youth ($)[a]	Cost per LOC ($)[b]	Cost per LOC per Youth ($)[b]	% of LOC Total ($)[b]
Out-of-State	146,521	24,420	126,682	21,114	1.1%
Hospital Residential	1,310,785	40,962	987,040	30,845	8.8%
Community High Risk	583,189	58,319	571,725	57,173	5.1%
Community Residential	4,453,225	27,660	3,812,659	23,681	34.0%
Therapeutic Group Home	2,260,144	23,300	1,816,415	18,726	16.2%
Therapeutic Family Home	2,733,912	16,981	2,125,250	13,200	19.0%
Respite Home	57,446	9,574	3,900	650	0.0%
Intensive Day Stabilization	0	0	0	0	0.0%
Partial Hospitalization	0	0	0	0	0.0%
Day Treatment	0	0	0	0	0.0%
Multisystemic Therapy	869,419	6,440	424,192	3,142	3.8%
Intensive In-Home	1,901,570	4,179	1,009,510	2,219	9.0%
Flex	4,152,901	23,867	204,992	1,178	1.8%
Respite	177,763	5,079	40,412	1,155	0.4%
Less Intensive	139,530	34,882	19,418	4,855	0.2%
Crisis Stabilization	120,932	6,718	70,222	3,901	0.6%

Note: [a] Cost per youth represents the total cost for all services during the period allocated to level of care (LOC) based on duplicated youth counts. Thus, the average out-of-state cost per youth includes total expenditures for youth who received any out-of-state service. If youth received multiple services, the total expenditures for that youth are represented at multiple levels of care (duplicated US$). [b] Cost per LOC represents unduplicated cost (US$) for services at the specified level of care.

As previously noted, the number of youth receiving Hospital Residential services has seen a recent decrease. In conjunction with the decreased census, the current quarter witnessed a decrease in the average length of service in the Hospital setting. Accordingly, the total cost of services for youth who received Hospital Residential services during the quarter decreased from $1,381,989 to $1,310,785. The cost for Hospital Residential services also decreased ($987,040 compared to $1,017,818 in the prior quarter). However, the cost per youth increased from $32,139 to $40,962 for total costs and from $23,670 to $30,845 for Hospital Residential costs only.

Along with the decrease in authorization of Community-Based Residential (CBR) during the first quarter of fiscal year 2006, utilization of this service has been decreasing. Accordingly, the cost of CBR services decreased in the reporting quarter (i.e., first quarter of fiscal year 2006 compared to fourth quarter of fiscal year 2005) both in terms of total dollars and average cost per youth. Youth with high-risk sexualized behaviors who received treatment services in a Community High-Risk Program at some point during the quarter had the highest total cost per youth ($57,173 per youth), which has increased over time. For other types of residential treatment, the lowest cost per youth was for those who received services in Therapeutic Foster Homes ($13,200 per youth), which has been consistent over time.

In-Home (Intensive In-Home and MST) and Less Intensive services accounted for 13% of the unduplicated cost of services, which is a slight increase from the last reporting quarter (April 2005-June 2005) percentage of total costs for those categories. Youth receiving Intensive In-Home services at some point during the quarter cost an average of $4,179 per youth ($2,219 of which was for Intensive In-Home service expenditures only), which continues to be significantly less than the cost per youth in any residential program.

For those youth who received Ancillary Services, average cost per youth for the Flex funded services only was $1,179 per month and the average cost for all services to those youth who received one or more Ancillary services was $23,867 per youth. The average cost per youth for a child receiving a Flex-funded service at some point during the quarter also includes their service costs in other levels of care, and may include residential services. The high average total cost per youth for these services suggest that youth in out-of home placements account for a high percentage of youth receiving a Flex-funded service. A high proportion of Flex-funded services are travel-related including family visits when placement is off-island. As previously reported, CAMHD is in the process of adding travel costs to the MOA with the Med-QUEST Division for QUEST-eligible youth, allowing the State to recoup federal funds for a portion of this cost. This agreement will apply retrospectively.

Comprehensive information on expenditures beyond the services tracked by CAMHMIS is obtained through the Department of Accounting and General Service's Financial Accounting Management Information System (FAMIS). For this report, FAMIS provided information regarding total general fund expenditures and encumbrances for the central and branch offices that are reported in the Performance Measures section. However, it is important to note that FAMIS tracks payments and encumbrances when they are processed at the Departmental level. Due to the time lag between service provision and payment, the CAMHMIS and FAMIS systems do not track the same dollars within any given period. Therefore, estimates provided here are used for general guidance, and detailed financial analysis is conducted by CAMHD Administrative Services.

Recent developments to the chart of accounts in the financial accounting system allows for more specific coding of purchases into specific service categories. Therefore, as the system continues to develop and new reporting functions are programmed, comprehensive financial reports providing detailed service expenditures should be available from FAMIS. This should lead to reduced burden for manual reporting and increase the capacity of the fiscal section to perform timely and thorough financial analysis.

Services for Youth With Developmental Disabilities

CAMHD entered into a Memorandum of Agreement (MOA) with the Developmental Disabilities Division (DDD) of the Department of Health in July 2002 for the purposes of serving the needs of those youths with mental retardation and/or developmental disabilities and/or autism (target population) who had previously received respite and out-of-home services through CAMHD. The MOA transferred funding and personnel to DDD so that these children could receive appropriate individualized supports consistent with national best practices in developmental disabilities.

The table below summarizes the expenditure of dollars for respite services provided by DDD from July 1, 2002 through December 31, 2005:

Table 9. Expenditures to Date for Respite by Island

Island	# Youth Served	% of Total Youth	Total Cost Per Island	% of Total Dollars Expended	Average Cost Per Youth
Oahu	73	55%	$148,303.93	44%	$2,031.56
Hawaii	34	26%	$89,714.00	27%	$2,638.65
Kauai	11	8%	$61,644.50	18%	$5,604.05
Maui	14	11%	$37,358.00	11%	$2,668.43
Total Youth	132	Total Dollars Expended (July 2002 - December 31, 2005)			$337,020.43

Note: There are currently no reports of respite expenditures for the period October 2005 through December 2005.

Although the MOA ended on June 30, 2004, DDD continues to provide case management, individual support, respite, and out-of-home support services for the identified target population. DDD utilized the respite monies transferred from CAMHD as part of its state match for its HCBS-DD/MR Medicaid waiver program, thereby maximizing state funds and qualifying DDD services for federal reimbursement.

Respite Services

The target population received at least one support service from the DDD service system. For this current quarter, October 1, 2005 through December 31, 2005, the following table shows the utilization of various DDD funded services (short term) that families accessed to meet their needs:

Table 10. Other Service Options Utilized by Respite Recipients

DDD Funded Services	# of Users
Purchase of Services - Partnerships in Community Living	8
DOH - DDD Respite	35
Family Support Services Program	11

In addition, since July 2002, DDD has admitted 61 of the target population into the Home and Community Based Services – DD/MR (HCBS-DD/MR) Medicaid waiver program. Of the 61 individuals, 4 were admitted in the second quarter of FY06. There were no client discharges from waiver during this time period.

Based on the latest expenditure information available for the period July 1, 2005 through September 30, 2005, the following table shows the number of clients in the target

population and total dollars spent for two of the HCBS-DD/MR Medicaid waiver services, respite and personal assistance:

Table 11. Waiver Service Options Utilized by Respite Recipients

Waiver Services (July 1, 2005 – September 30, 2005)	# of Clients	Total $
Respite	9	$20,675.00
Personal Assistance	38	$324,157.00

Note: Amounts are rounded off to the nearest dollar.

Residential Services

DDD extended the Individual Community Residential Support (ICRS) contract until June 2006. Currently, ICRS provides for special treatment facility services for three youths. A third youth, part of the identified in the target population, was admitted to the facility in December 2006 in coordination with the DOE.

All but one individual of the thirteen youths that originally received ICRS services have been admitted to the HCBS-DD/MR waiver program. This one individual remains in a psychiatric facility, and, although discharge has been recommended, transition to community-based services has not occurred.

Performance Measures

CAMHD performance measures to demonstrate adequacy of services, results, infrastructure, and key practice initiatives are found in this section. If baseline performance falls below the established goals, CAMHD systematically examines the trends and any barriers, and develops strategies to achieve each goal. A stable pattern of results (i.e., a flat line) indicates that CAMHD is sustaining performance at baseline levels. A line that exceeds its benchmark indicates that CAMHD has surpassed its performance goals.

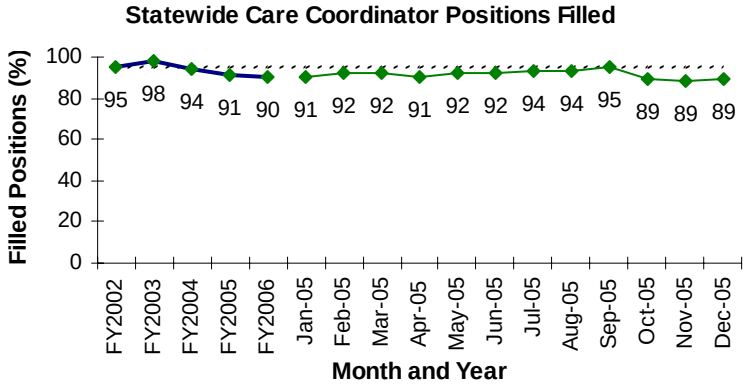
Performance measures linked to "measures of sustainability" are noted by an asterisk (*).

CAMHD will maintain sufficient personnel to serve the eligible population

Goal:

⇨ 95% of mental health care coordinator positions are filled.*

Over the reporting period, CAMHD had an average of 89% of care coordinator positions statewide filled, which was 6% below the performance goal, and is below last quarter's performance of 91%. This quarter's result reflects the ninth consecutive quarter the performance goal was not met. The length of time it takes to fill care coordinator positions within the State personnel hiring process continues to impact performance on this goal.



The percentage of filled Care Coordinator positions over the quarter for each Family Guidance Center is displayed below.

COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC	KAUAI
88%	90%	89%	88%	100%	85%	89%

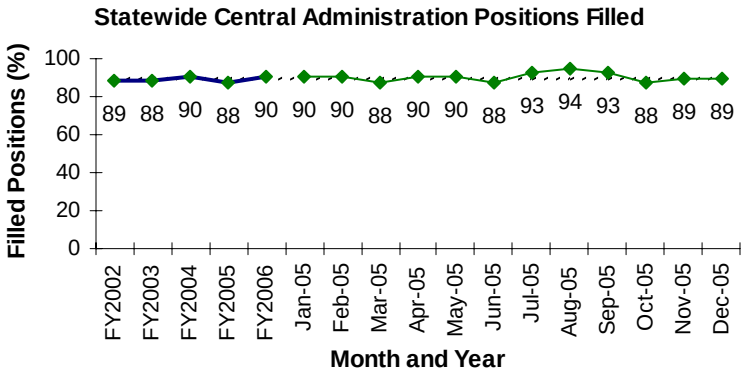
As seen above every FGC except for Honolulu fell below the performance goal. Each of the centers other than Honolulu experienced one to three vacancies. The inability to fill positions impacts caseloads, and as explained in an analysis later in this report, overall FGC performance. As a strategy to improve human resource management, Branch Chiefs receive weekly briefings from the CAMHD personnel office to facilitate communication and understanding when hiring obstacles are encountered.

Goal:

⇨ 90% of central administration positions are filled.*

The performance target did not meet the desired performance with an average of 89% of central administration positions filled over the quarter. This is below last quarter's performance of 92%.

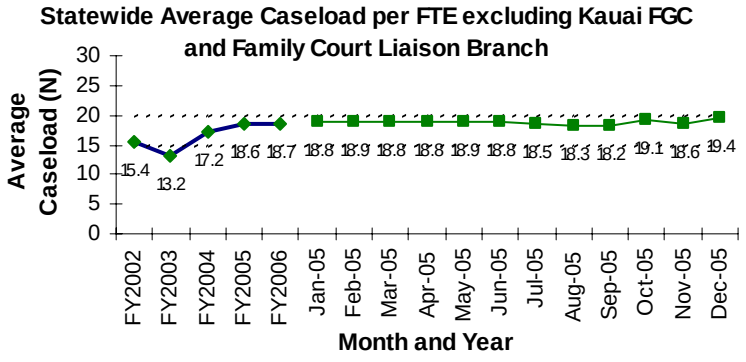
Vacant positions are distributed throughout central administration, with all offices experiencing some vacancies. Vacant positions are reviewed and recruited where possible through the civil service system to support the realignment of exempt and civil service positions.



Goal:

⇨ Average mental health care coordinator caseloads are in the range of 15 - 20 youth per full time care coordinator.

The statewide average caseload for the second quarter was within the target range at 19.0 youth per full time care coordinator equivalent (FTE), which meets the performance goal for the measure. Each of the three months in the quarter met the performance expectation. CAMHD expects that care coordinator caseloads consistently fall in the range of 15 to 20 youth per full time care coordinator in order to provide quality intensive case management services. Average caseloads have consistently been in the targeted range since the beginning of fiscal year 2004 and have been in the high end of the range over the past year and a half.



The average caseload performance target was not met for Central Oahu, Leeward Oahu, and the Big Island FGCs where caseloads were above the

expected range. As explained in last quarter's report, the registered population at Leeward Oahu has shown a consistent pattern of expansion and has grown by 24% over the same period of last year, whereas the number of allocated care coordinator positions has increased by 10%. The Big Island FGC population is comparable to the same period of last year, but three care coordinator position vacancies were experienced. In addition to larger populations, Leeward and the Big Island have the additional socio-economic factors that impact their population, which adds to challenges in case management.

Average Caseloads by Family Guidance Center

	COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC
2nd Quarter Average	21	22	16	18	17	21

The calculation of average excludes Kauai, which serves both high-end and low-end youth through the Mokihana project, and therefore have higher caseloads. Family Court Liaison Branch is also excluded because staff provide direct services to youth while at Detention Home or Hawaii Youth Correctional Facility, the majority of which are receiving care coordination from another Family Guidance Center.

CAMHD will maintain sufficient fiscal allocation to sustain service delivery and system oversight

Goal:

⇨ Sustain within quarterly budget allocation.

CAMHD met the goal for sustaining within its budget. The reporting quarter for this performance measure is July 2005-September 2005, which allowed for closing of the contracted agency billing cycle. Expenditures for Branch and Services totals were below budget ($131,000 and $105,000 respectively). The Central Office total was over budget by $148,000. Total variance from the budget for the reporting quarter was under projection by $88,000. Sufficient funds were encumbered for all expected service costs.

Variance from Budget (in $1,000's)

	FY 2002 Average	FY 2003 Average	FY 2004 Average	FY2005 Average	FY2006 Average	2005.1	2005.2	2005.3	2005.4	2006.1
Branch Total	$164	-$150	$20	-$242	-$131	$20	-$337	-$338	-$312	-$131
Services Total	$798	-$4,175	-$1,849	-$102	-$105	-$2	-$203	-$155	-$49	-$105
Central Office Total	-$189	-$388	-$314	$68	$148	-$15	-$30	$86	$231	$148
Grand Total	$773	-$4,713	-$2,142	-$276	-$88	$4	-$571	-$407	-$129	-$88

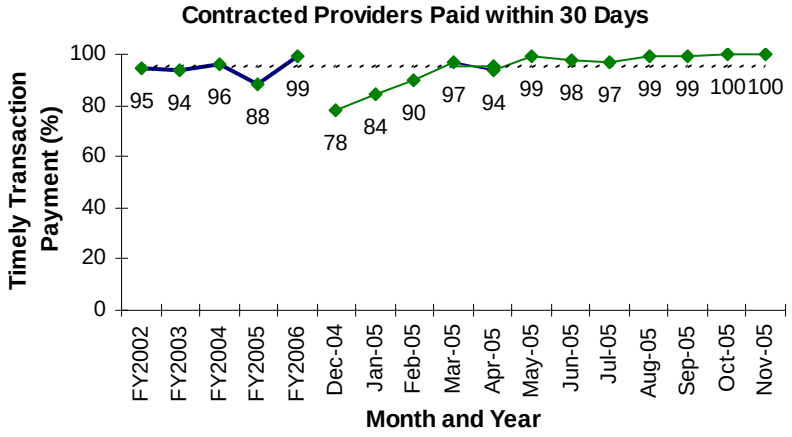
CAMHD will maintain timely payment to provider agencies

Goal:

⇨ 95% of contracted providers are paid within 30 days.

This quarter, 100% of contractors were paid within the 30-day window over the quarter. This is an improvement over last quarter's average of 98% of contracted providers paid within 30 days. The performance goal

has been met consistently since May 2005 demonstrating that improvement strategies implemented by the CAMHD Fiscal Section have been sufficient in sustaining a high level of performance



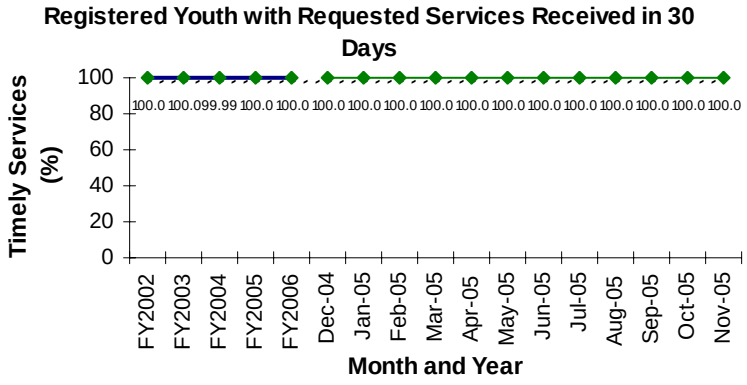
As is standard for this report, the quarter's data is available for the first two months of the quarter (October and November 2005) and includes September 2005.

Goal:

⇨ 98% of youth receive services within thirty days of request.*

CAMHD will provide timely access to a full array of community-based services

The goal was met for the quarter with 100% of youth provided timely access to services. Data are for the first and second month of the reporting quarter (October and November 2005) as third month data are not available at the time of publication. September 2005 data are included in the average for the quarter. This measure has consistently met the goal since it began to be tracked in fiscal year 2002.

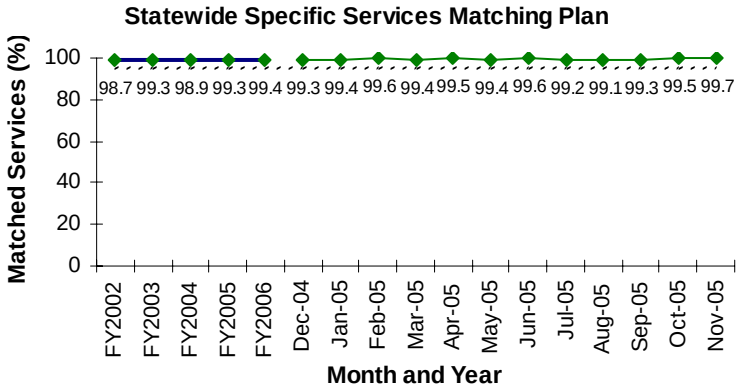


Goal:

⇨ 95% of youth receive the specific services identified by the educational team plan.*

CAMHD continued to demonstrate strong performance on this measure. Over the quarter, 99.6% of youth received the specific services identified by their team plan. Data are for the first and second month of the

reporting quarter (October and November 2005) as third month data are not available at the time of publication. September 2005 data are included in the average for the quarter. This measure includes SEBD youth who do not have an educational plan.



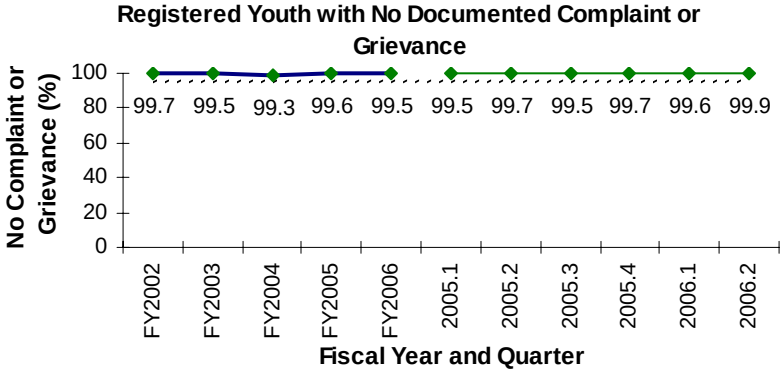
In the quarter, service mismatches occurred in ten complexes versus eighteen in the previous quarter. Castle Complex had two youth receiving mismatched services. The remaining complexes experiencing mismatches had one a piece. Hilo, Kapolei, Maui, and Baldwin Complexes and Olomana had continuing mismatches from the previous quarter. Hilo has had at least one mismatch for the last nine quarters (since June-August 2003). The regional FGCs and the Utilization Management Committee regularly conduct analyses of the mismatches. Recommendations for service expansion have been collected and have been integrated where appropriate into the RFP for the updated service array.

CAMHD will timely and effectively respond to stakeholders' concerns

Goal:

⇨ 95% of youth served have no documented complaint received.*

99.9% of youth served in the quarter had no documented complaint received, which exceeds the performance goal. The target was met across all Family Guidance Centers. Performance on this goal has been sustained since it was established in June 2001.



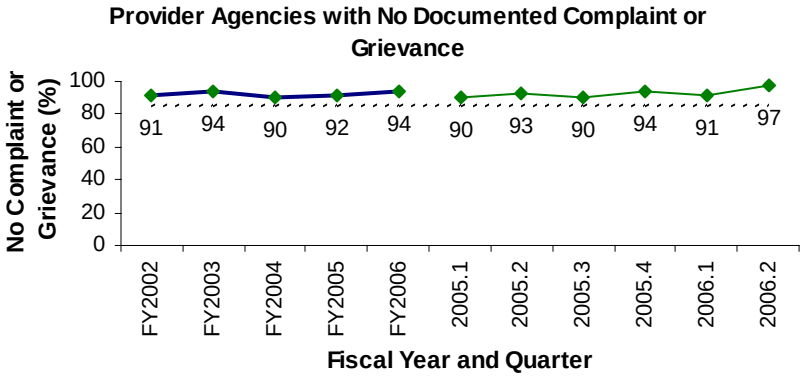
In the quarter, there were complaints received from 4 youth (or someone complaining on their behalf) representing 4 complexes statewide as compared to 7 youth with documented complaints representing 5 complexes last quarter. There was one complaint for each of the

following complexes: Kapolei, Nanakuli, Castle, and King Kekaulike. There were no noticeable trends in the data.

Goal:

⇨ 85% of provider agencies have no documented complaint received.

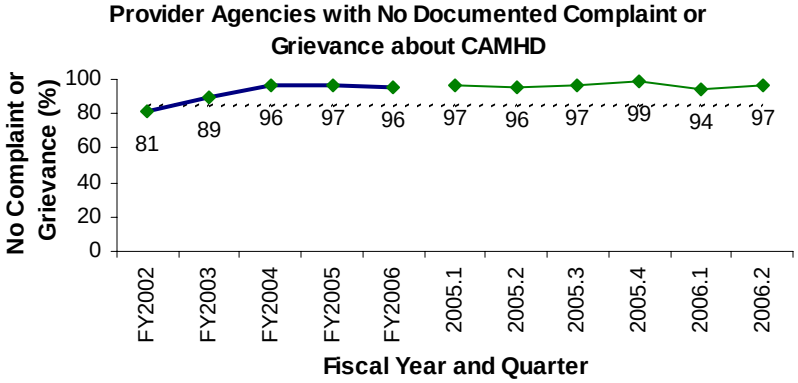
97% of provider agencies had no documented complaint registered about their services, which met the performance goal. The performance target for this measure has been consistently met since the second quarter of fiscal year 2004.



Goal:

⇨ 85% of provider agencies will have no documented complaint about CAMHD performance.*

In the quarter, 97% of agencies in the CAMHD provider network had no documented complaint or grievance about CAMHD. This measure has consistently met the performance goal since the beginning of FY 2003.



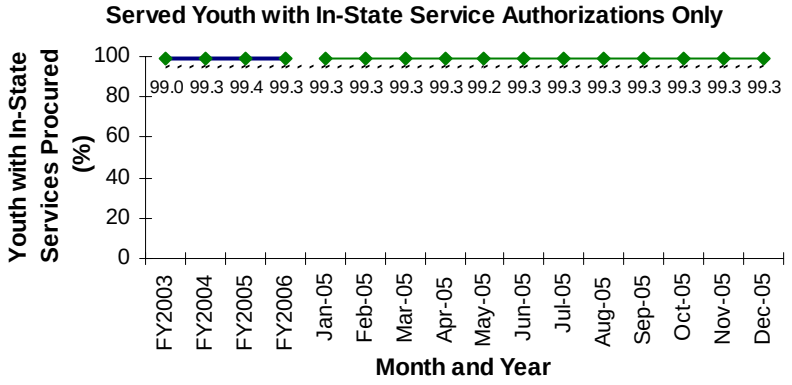
Youth will receive the necessary treatment services in a community-based environment within the least restrictive setting

Goal:

⇨ 95% of youth receive treatment within the State of Hawaii.*

In the quarter, an average of 99.3% of CAMHD registered youth served received treatment within the State, which exceeds the goal. Six youth received services in out-of state treatment settings in each month of the quarter.

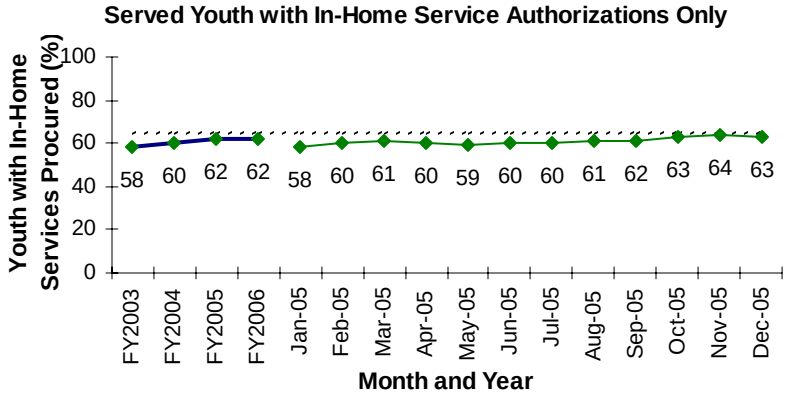
These data represent only youth registered with CAMHD who were in out-of-state treatment settings in the reporting quarter, and does not represent youth who may have this service paid for by other State agencies.



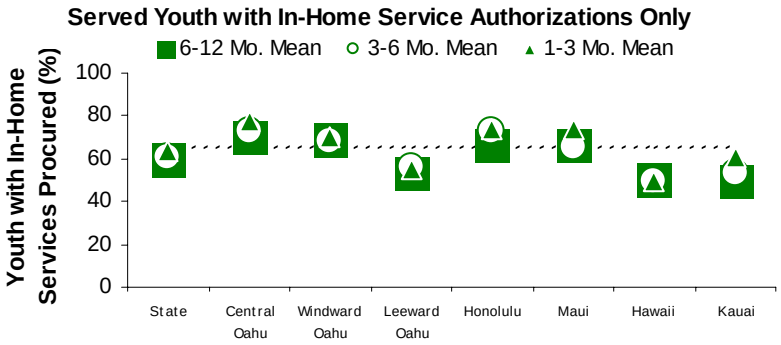
Goal:

⇨ 65% of youth are able to receive treatment while living in their home.

An average of 63% of youth were served in their home communities during the quarter, which was 2% below the performance goal. This quarter's performance was above last quarter's average of 61% of youth served in their homes.



There was variable performance across the Family Guidance Centers in meeting the goal as can be seen below. The goal was met for Central Oahu (77.8% served in-home) exceeding last quarter's performance, Windward Oahu (70.4% served in-home), Honolulu (74.2% served in-home), and Maui (74% served in-home). With more than half of the FGCs exceeding the performance goal in the quarter, it is suggested that the goal be re-evaluated within the context of this emerging trend.



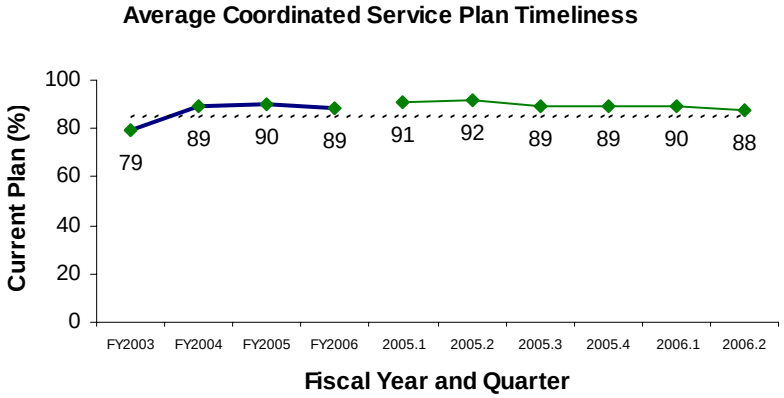
Serving youth in their homes and home communities when such services are likely to be effective continues to be a core value for CAMHD. Both the Leeward Oahu and Hawaii Family Guidance centers have historically had higher out-of-home service rates, however the proportion of youth showing positive outcomes from these centers are comparable to other centers in the state.

CAMHD will consistently implement an individualized, child and family centered planning process

Goal:

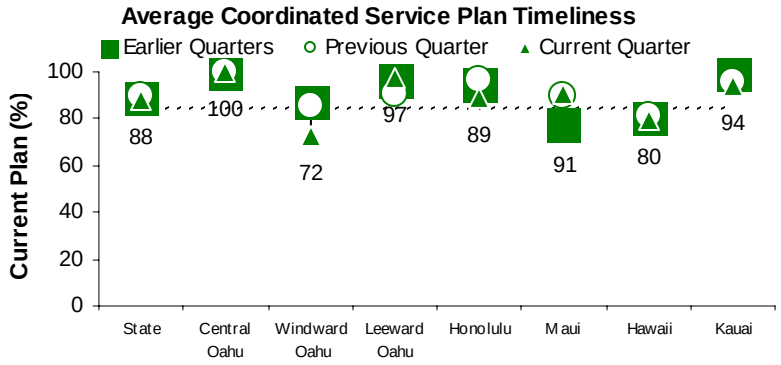
⇨ 85% of youth have a current Coordinated Service Plan (CSP).*

CAMHD's performance in this measure met the performance goal for the reporting quarter with 88% of youth across the state having a current CSP. The performance has remained stable and the goal has been met for the past two and a half years.



Note: This data includes youth who were newly admitted to CAMHD who have not yet had a CSP developed, but does not include youth awaiting an assessment for determination of SEBD.

"Current" is defined as having been established or reviewed with the CSP team within the past six months. Quarterly reviews of timeliness are conducted to assess for current CSPs. Registered youth receive an initial Coordinated Service Plan within 30 days of determination of eligibility.



Trend data for each FGC are displayed above. Hawaii and Windward FGCs plan timeliness were below the performance goal. Hawaii FGC's improvement strategies of increasing supervision and filling a vacant Mental Health Supervisor position has had some impact in performance of this indicator. However, as predicted in last quarter's report, vacancies in Mental Health Care Coordinator positions and average caseloads that exceed the targeted caseload size are presenting challenges to meeting this performance goal.

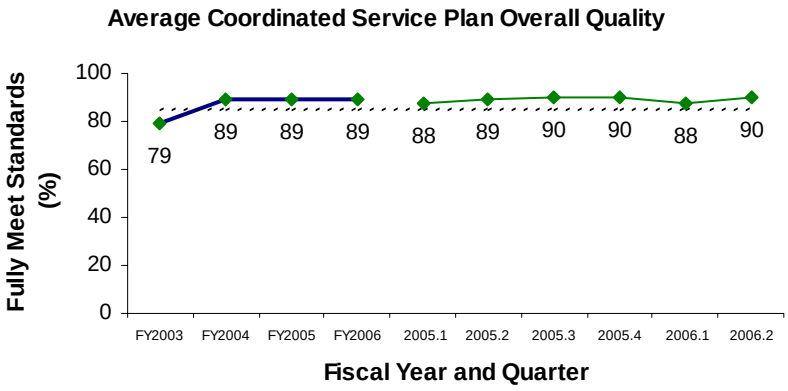
Windward FGC has shown decreases in timeliness over the past two quarters. At 72% timeliness of CSPs, Windward is substantially below the performance of all other FGCs. Focused improvement strategies will need to be implemented over the next quarter in order to assure all youth have a current coordinated service plan.

Maui FGC's quality improvement strategies described in previous reports appear to have been successful, as the FGC is assuring timely plans at well above their performance in earlier quarters.

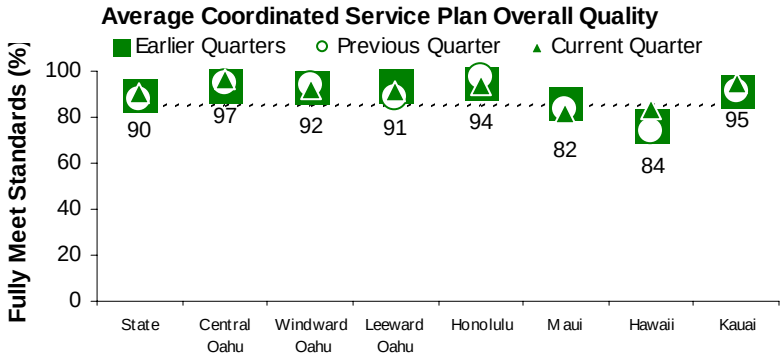
Goal:

⇨ 85% of Coordinated Service Plan review indicators meet quality standards.*

The goal for this measure was met statewide in the reporting quarter with 90% of CSPs sampled meeting overall standards for quality. The goal has been met for the past two and a half years.



CSPs are reviewed quarterly by the FGCs to determine if they meet the standards for effective plans. In order for a CSP to be deemed as acceptable overall, there must be evidence that the plan is meeting key quality indicators including stakeholder involvement, clear understanding of what the child needs, individualization of strategies, identification of informal supports, long-term view, plan accountability, use of evidence-based interventions, crisis plans and several other key measures. During the current quarter, the specific domains with the lowest quality ratings were in contingency and crisis planning and stakeholder involvement at the CSP meetings.



As seen in the chart above, the goal was met or exceeded by all FGCs with the exception of Maui and Hawaii FGCs. Maui's performance declined slightly from last quarter, while Hawaii's improved considerably. Both Centers are implementing more focused supervision in this area.

Mental Health Services will be provided by an array of quality provider agencies

Goal:

⇨ 85% of performance indicators are met for each Family Guidance Center.

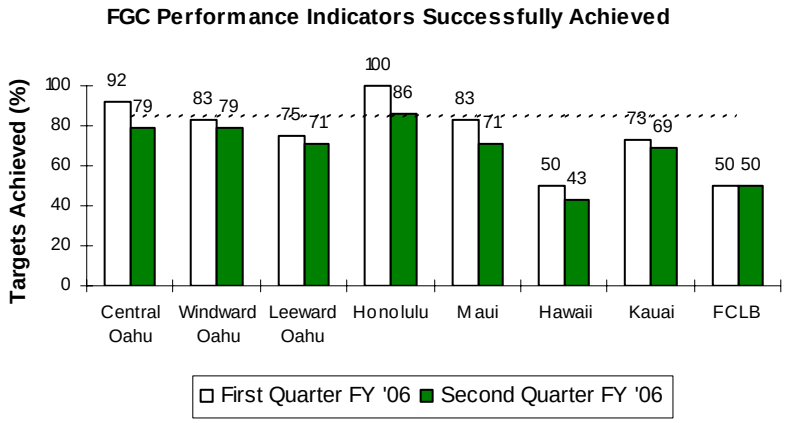
Only one of the eight Family Guidance Centers, Honolulu, met the performance goal this quarter. Family Guidance Center performance is evaluated based on the percentage of performance targets that are met or exceeded in the quarter. Performance targets are comprised of the relevant measures presented in this report, and include individual FGC performance on: personnel measures, expenditures within budget, grievances, access to services (service gaps/mismatches), least restrictive environment (served in-home), timeliness and quality of coordinated service plans, performance on internal reviews, improvements in child status, and family satisfaction.

Across all branches, 78.8% of all goals were met in the quarter, compared to 74.6% in the last quarter, and 75.3% over the same period last year.

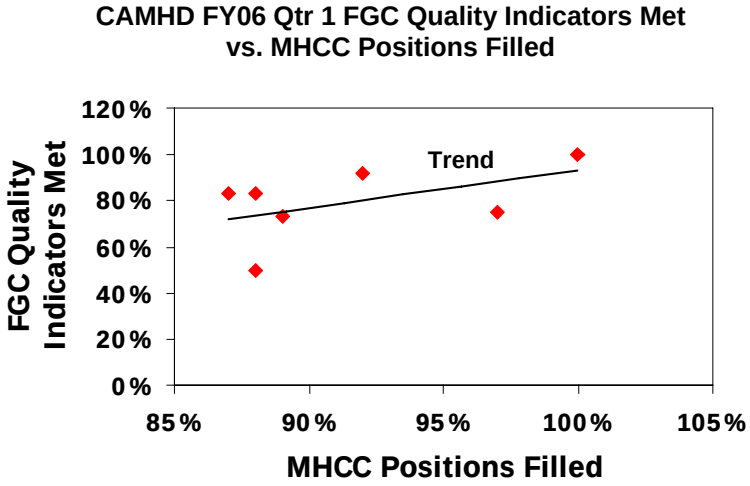
Central Oahu, Windward Oahu, Leeward Oahu, Maui, Big Island, and Kauai FGCs and the Family Court Liaison Branch (FCLB) did not meet performance goals. Windward, Leeward, and Maui showed improvement over the previous quarter and over the same period of last year. Kauai

FGCs showed improvement over the previous quarter, but performance was stable compared to the same period of last year.

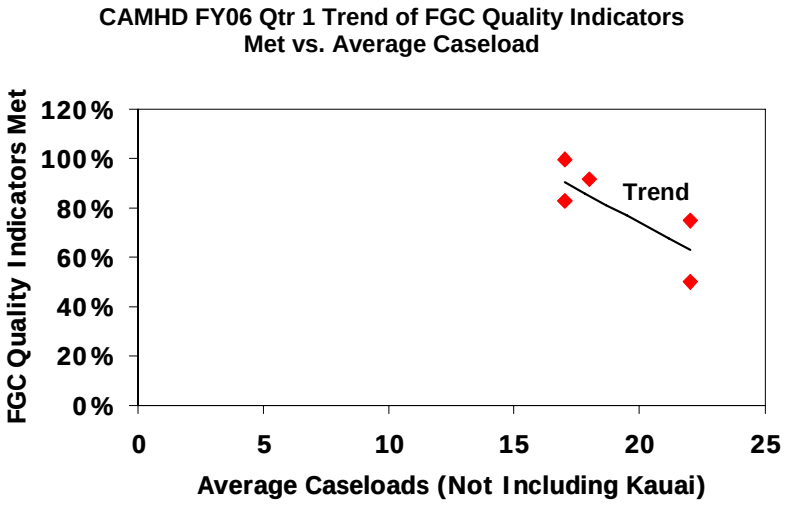
Due to its unique configuration, the FCLB is only evaluated for the two indicators of expenditures within budget and percent of youth showing improvement on the CAFAS or ASEBA. Therefore these results tend to be highly variable and are not directly comparable to other branches.



Care coordinator vacancies and caseloads appear to be primary factors influencing the ability of FGC to meet performance goals. In the reporting quarter, of the seven FGCs, only one (Honolulu) had 95% of their positions filled. Half of the FGCs had caseloads within the 1:15-20 range. A full analysis of impact of vacancies on performance has yet to be conducted. However, as seen in the chart below, at the aggregate level last quarter (July-September 2005), the percentage of performance indicators met by the FGCs increased where more MHCC positions were filled.



Additionally, as seen below, the percentage of FGC indicators met dipped sharply as average caseloads increased.



The branches did well on indicators of:

- timely access to services,
- documented complaints from consumers, and
- serving youth in the State.

One or two branches struggled with:

- maintaining within budget,
- timeliness of Coordinated Service Plans,
- quality of Coordinated Service Plans, and
- youth showing improvements as measured by the CAFAS or ASEBA,

Several branches did not meet goals for:

- average caseloads,
- serving youth while they are living at home,
- youth with acceptable child well-being in Internal Reviews, and
- completing the CAFAS or ASEBA.

All but one branch (Honolulu) did not meet the performance goal for:

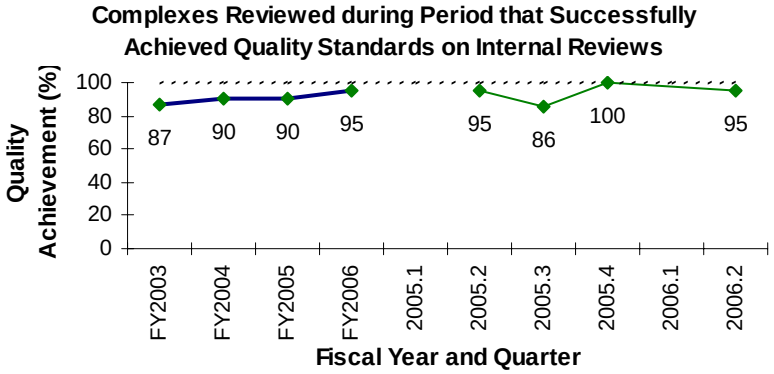
- filling care coordinator positions.

Performance goals not met by a Family Guidance Center are addressed through specific improvement strategies developed by the FGC internal quality assurance committee, and reported up through the CAMHD Performance Improvement Steering Committee. Each FGC management team tracks the implementation of their improvement strategies.

Goal:

⇨ 100% of complexes will maintain acceptable scoring on internal reviews.*

Complex internal reviews for the school year started in the second quarter. Of the twenty-two complexes reviewed, 95% met the performance goal. One complex, Konawaena, did not meet the goal. Acceptable scoring continues to be defined as achieving acceptable system performance for 85% of cases reviewed. The performance target is for 100% of complexes to meet the goal for acceptable system performance.

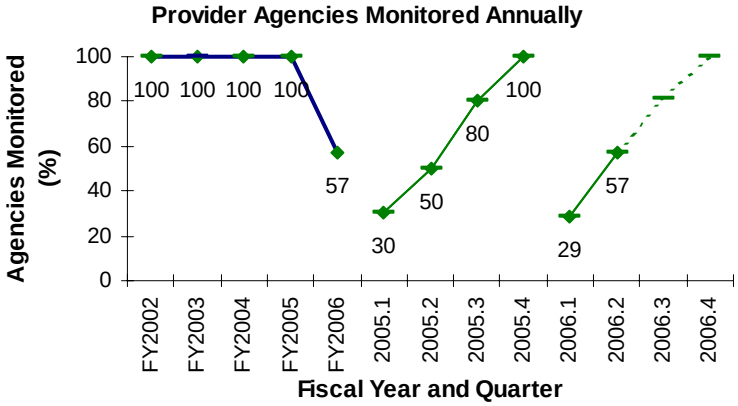


Mental Health Services will be provided by an array of quality provider agencies

Goal:

⇨ 100% of provider agencies are monitored annually.

The CAMHD Performance Management Section conducts comprehensive monitoring of all agencies contracted to provide mental health services. In the quarter, 57% of all agencies contracted to provide direct mental health services were monitored as scheduled, which met the targeted goal. Six agencies, representing seven contracts and eight levels of care were monitored in the second quarter.



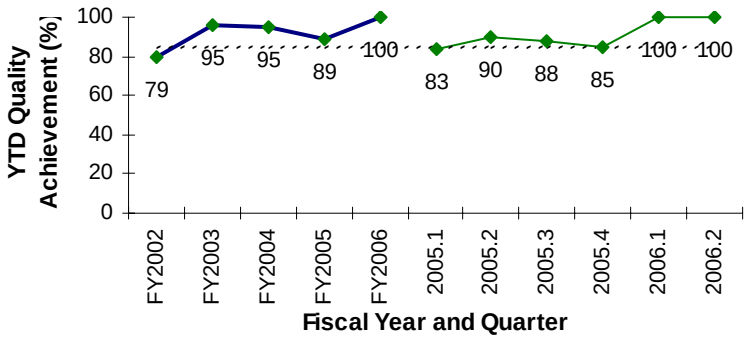
Goal:

⇨ 85% of provider agencies are rated as performing at an acceptable level.

At least annually, provider agencies are reviewed across multiple dimensions of quality and effective practices. In the reporting

quarter, 100% of the provider agencies reviewed in the quarter were determined to be performing at an acceptable level, which met the performance goal for this measure. Because monitoring occurs over an annual season, the annual indicator is more reliable than the quarterly indicator. Because fiscal year 2005 displayed a mild performance decrease over fiscal year 2004, this indicator is being closely monitored.

Provider Agencies Performing at an Acceptable Level



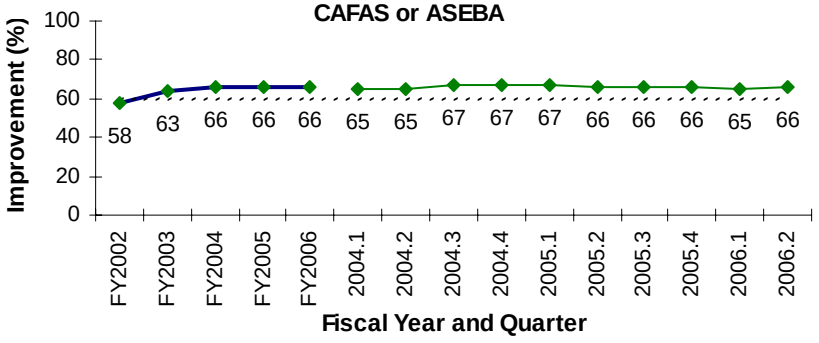
CAMHD will demonstrate improvements in child status

Goal:

⇨ 60% of youth sampled show improvement in functioning since entering CAMHD as measured by the Child and Adolescent Functional Assessment Scale (CAFAS) or Achenbach System for Empirically Based Assessment (ASEBA).*

To monitor performance of CAMHD's goal of improving the functioning, competence and behavioral health of youth, care coordinators are required to submit the CAFAS and ASEBA for each youth. The performance goal is measured as the percentage of youth sampled who show improvements since entering CAMHD services and is set at 60%.

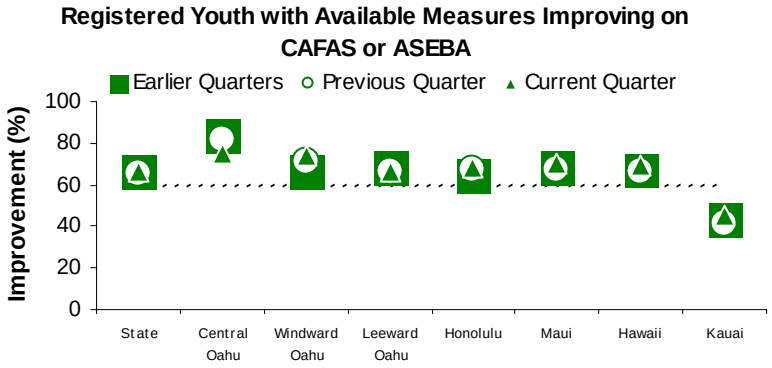
Registered Youth with Available Measures Improving on CAFAS or ASEBA



In the reporting quarter, for youth with data for these measures, 66% were showing improvements since entering the CAMHD system, which exceeds the performance goal.

This indicator had demonstrated improvements from fiscal year 2002 to 2004, but has settled on a new plateau of approximately two-thirds of youth showing improvement at any given point in time.

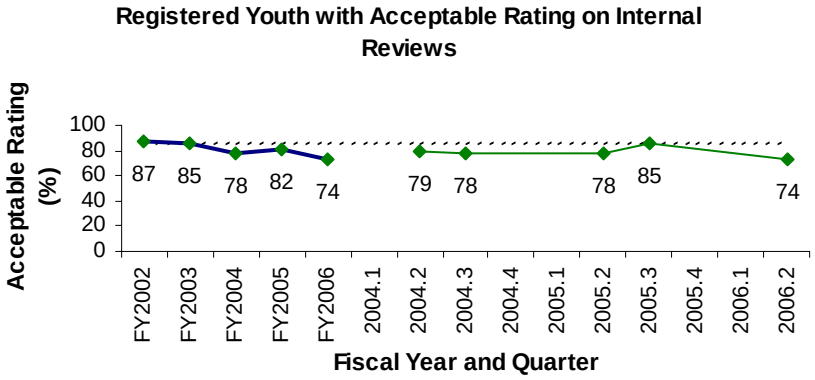
Most branches are performing near the state average with the exception of Kauai, which historically has performed below the average. Kauai differs from the other branches due to the Mokihana project, so the branch-to-branch results are not directly comparable. Central Oahu, which had been performing well above the state average experienced a dip in performance this quarter.



Goal:

⇨ 85% of those with case-based reviews show acceptable child status.

Of youth receiving care coordination and services through CAMHD, 74% were found to be doing well in measures of child well-being as measured through Internal Reviews. Child status was a concern for several youth reviewed in the Central, Maui, Honolulu and Big Island service areas.



Families will be engaged as partners in the planning process

Goal:

⇨ 85% of families surveyed report satisfaction with CAMHD services.

CAMHD performs an annual consumer survey in the spring of each year and results were reported last quarter. Therefore, new data are not available for the current report.

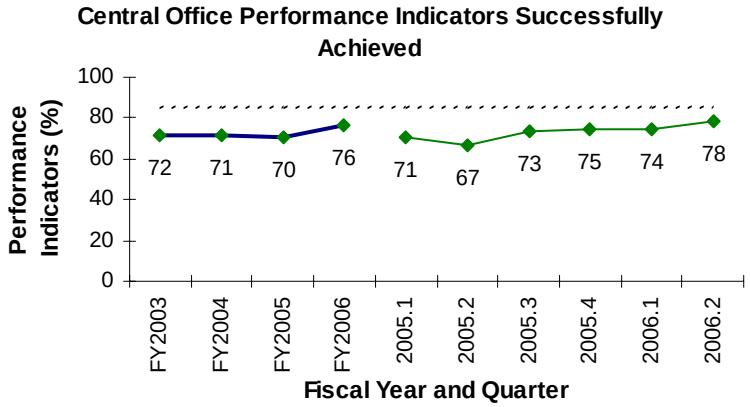
The comprehensive report of the most recent results can be found on the CAMHD website at http://www.hawaii.gov/health/mental-health/camhd/library/pdf/rpteval/cs/cs005.pdf.

There will be state-level quality performance that ensures effective infrastructure to support the system

Goal:

⇨ 85% of CAMHD Central Office performance measures will be met.

CAMHD's Central Administrative Offices utilize performance measures for each section for accountability and planning. Central Office measures are approved and tracked by the CAMHD Expanded Executive Management Team (EEMT). There are a total of 36 measures currently tracked by EEMT. Of the 32 measures available in this quarter, 25 or 78% of measures were successfully met, which falls short of meeting the performance goal for this quality indicator, but shows a slight increase over last quarter's performance, and is part of an improving trend. In the quarter, the measures that fell below their goals continued to revolve around timeliness and issues related to the impact of staff vacancies.

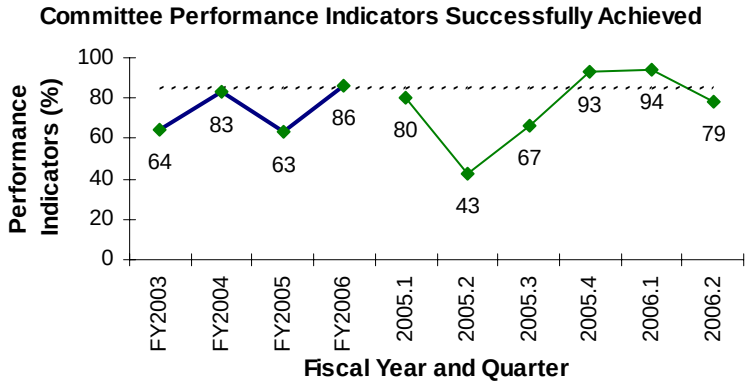


Improvements for Central Office performance measures are managed by respective sections of CAMHD. When solutions require a broader organizational intervention, these are discussed on the regular Expanded Executive Management Team level, and are tracked for implementation.

Goal:

⇨ 85% of CAMHD State Committees performance measures will be met.

The CAMHD Performance Improvement Steering Committee (PISC) reviews data for its core committees, which include Grievance Appeals, Compliance, Credentialing, Evidence Based Services, Information System Design, Policy & Procedure, Safety & Risk Management, Training, and Utilization Management.



A total of 20 measures are tracked and reported on in the monthly meeting. Similar to Central Office measures, results for each indicator are discussed in PISC meetings in order to identify improvement strategies that are implemented by respective CAMHD section managers.

In the quarter, of the 14 measures available in this quarter, 79% were successfully achieved through the work of the CAMHD Committees. This is a decline over last quarter's performance of 94% of measures met. The only committee measures not meeting the benchmark involved the percent of licensed and unlicensed practitioners recredentialed prior to their expiration date and the number of articles coded by the Evidence-Based Services committee during the quarter. However, these committees did successfully meet their other measures. Each committee not meeting their benchmark is required to present improvement strategies to PISC.

Summary

Slightly more than half of the performance goals were met or exceeded in the second quarter of fiscal year 2006 (October 2005-December 2005), which is a decline in overall performance over last quarter.

For a point of reference, the asterisked measures are those that had historically been linked to Federal Court benchmarks under the Felix Consent Decree. Of these "Sustainability" measures, indicators met the performance goal in the reporting quarter except for the following measures:

- Filled Care Coordinator Positions, which was 6% below targeted performance and a decrease of 2% from last quarter's performance.
- Filled Central Administration Positions, which was slightly below (1%) the targeted performance goal and 3% below last quarter's performance.
- Complexes Maintaining Acceptable Scoring on Internal Reviews, which was 5% below targeted performance. One complex, Konawaena, did not meet the goal.

The following were measures that met or exceeded goals:

- Care Coordinator caseloads within the range of 1:15-20 youth
- Maintaining services and infrastructure within the quarterly budget allocation
- Contracted providers paid within 30 days
- Timely access to the service array:
  - Youth receiving services within 30 days of request*
  - Youth receiving the specific services identified on their plan*
- Timely and effective response to stakeholder concerns:
  - Youth with no documented complaint received*
  - Provider agencies with no documented complaint received
  - Provider agencies with no documented complaint about CAMHD performance*
- CAMHD-enrolled youth receiving treatment within the State of Hawaii*
- Coordinated Service Plan timeliness*
- Coordinated Service Plan quality*
- Performance Indicators met by the Honolulu Family Guidance Center
- Monitoring of provider agencies
- Quality service provision by provider agencies
- Improvements in child status as demonstrated by CAFAS or ASEBA*

The following measures were below targeted performance with observed decreases, and will require implementation of improvement strategies developed by the appropriate monitoring bodies.

- Filled Care Coordinator positions*
- Filled Central Administration positions*
- Performance Indicators met by the Central Family Guidance Center
- Performance Indicators met by the Windward Family Guidance Center
- Performance Indicators met by the Leeward Family Guidance Center
- Performance Indicators met by the Maui Family Guidance Center
- Performance Indicators met by the Hawaii Family Guidance Center
- Performance Indicators met by the Kauai Family Guidance Center

- Complexes maintaining acceptable scoring on Internal Reviews as one complex scored below 85%.
- Child Status as measured by Internal Review Results
- State Committee performance indicators

The following measure was not completed this quarter due to regular annual scheduling:

- Overall satisfaction with CAMHD services

Of the 29 performance measures completed during this quarter, 15 or 52% of performance indicators met or exceeded goals. Three measures that met their performance goals last quarter did not meet goals this time. A little more than half of the measures experienced performance declines. Of the original "Sustainability" measures, three (Filled Care Coordinator positions, Filled Central Administration positions, and Complexes Maintaining Acceptable Scoring on Internal Reviews) did not meet the performance goal, which increased slightly over the previous quarter. Challenges to filling positions remain and are actively being address through the reorganization and civil service replacement initiatives. Vacancies in the MIS and Performance Management sections continue to challenge ongoing operations. Additionally, performance areas of concern in the Family Guidance Centers are largely impacted by vacancies and the time it takes to fill positions.